FHHQ

Naval District Washington MWR Fitness Centers
Naval Support Activity Washington
MWR Fitness Centers
Morale Welfare and Recreation
Washington, DC 23023
Phone: (202) 433-2282; 433-2962

To be completed by MWR Fitness Staff Only
FHHQ Reviewed by: _____ Date: _____
CSI Input by: _____ Date: _____
MWR Card Issued by: _____ Date: _____
Fit Evaluation Date: _____ Compl by: _____
Fit Orientations: CV ____ ST ____ FLEX ____ HL/N _____
Fit Consultation Date: _____
□ Physician Release Date: _____
□ Initial FHHQ □ Renewal FHHQ Date: _____

FHHQ (Fitness Health History Questionnaire)

Name (Last, First MI) Rate/Rank
_____ _____
_____

□ Active Duty □ Guard □ Reserve □ Retired □ Dependant
□ DOD Civilian □ Contractor

Command Name: _____ Location: □ WNY □ ANA □ NAC □ USNO
□ Potomac Annex □ NRL □ Neb Ave

Bldg: _____ Last 6 of SSN: _____

Contact Info:
Address: _____
_____

Home Phone: _____
Work Phone: _____
Cell Phone: _____

Date of Birth (mo/day/yr): _____
In case of an emergency call: _____

Email: _____
Phone#: _____

Physician Name: _____ Phone: _____

Please complete the following: The Pre-Exercise Questionnaire is based on Health Risk Assessment designed by the Heart Foundation. The exercise screening profile is designed with your safety in mind. Please circle the appropriate score in any category that applies to you and add up your score to determine your Exercise and Health Habits Status.

PRIVACY ACT STATEMENT

AUTHORITY: 5 U.S.C. 301, Departmental Regulations.

PURPOSE: The primary use of this information is by MWR management officials to operate and manage a quality of life fitness program for active duty, reserve, and retired military personnel and their dependants, DoD civilians and DoD contract personnel; and to verify their eligibility for access to MWR fitness center facilities.

ROUTINE USES: The information will be used by MWR fitness staff fro process applications for membership to the center and to evaluate, plan and advise patrons of appropriate exercise programs and use of equipment. The DoD Blanket Routine Uses that appear at the beginning of the Navy's compilation of systems of records and notices apply to this system. A copy of these Blanket Routine Uses is available upon request from MWR Fitness Center staff.

DISCLOSURE: Disclosure of this information is voluntary. However, failure to provide identifying information may result in disapproval of your application to use the fitness center. Failure to complete health history information will result in not being provided advice and guidance regarding appropriate exercise programs and use of fitness equipment.

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Part 1

SCORE

1. AGE: 0-29 (0) 30-39 (1) 40-49 (4) 50-59 (5) 60+ (7) ( )

2. GENDER: Male (1) Female (0) ( )

3. FAMILY HISTORY

- An immediate family member has heart disease, high blood pressure, high cholesterol, or has had a heart attack or stroke
  - …..at or before the age of 56 (8)
  - …..between the ages of 56 to 65 (5)
  - …..after the age of 65 (3)

- No member of your immediate family (parents, brothers or sisters) has had a heart attack or stroke. Or have heart disease, high blood pressure, high cholesterol. ……(0)

( )

4. PERSONAL HISTORY

- You have had a prior heart attack, angina or stroke, and/or coronary bypass or other heart surgery…..(20)
- You have high blood pressure ……(10)
- You have high cholesterol (≥ 240 ml) and/or LDL cholesterol (≥ 160ml) ……(10)
- You have no history of heart disease, high blood pressure or high cholesterol and never suffered from a heart attack or stroke yourself. …….(0)

( )

5. SMOKING

- You currently smoke 20 or more cigarettes per day …..(12)
- You currently smoke up to 19 cigarettes per day ……...(6)
- You are a non-smoker, but smoked previously ……..(2)
- You have never smoked ……..(0)

( )

6. ALCOHOL Do you drink alcohol:

- > 4 alcoholic drinks per day ……(4)
- > 2 alcoholic drinks per day ……(2)
- < 2 alcoholic drinks per day ……(1)
- Not at all ……..…(0)

( )

7. MEDICAL HISTORY Circle below if you suffer from the following:

Diabetes (4) Arthritis (2) Psychological disorder (2) Asthma (2) ( )

Epilepsy (2) Back or Neck Problems (2)

Please write details about any of the above conditions: _____

_____

8. WEIGHT Would you assess yourself as being:

- …..very overweight (5)
- …..overweight (2)
- …..in a healthy weight range (0)

( )

9. EXERCISE HABITS Do you participate in:

- No activity at all in a typical week ……..(4)
- Non-aerobic exercise (gardening, manual work, slow walking, etc.) ……..(3)
- Aerobic exercise for 20 minutes 1-2 times per week ……..(2)
- Some form of aerobic exercise (jogging, brisk walking, swimming, cycling, aerobics) for at least 20 minutes at least 3 times per week ……...(0)

( )

10. STRESS

Some of the more common characteristics of high stress levels are: headaches, tension, pressed for time, easily angered, poor sleeping, and lack of concentration.

Please rate your level of stress.

High	…..(5)
Moderate	…..(4)
Low	…..(2)
Very Low	…..(0)

( )

TOTAL: ☐

Part 2: OTHER RISK FACTORS

Have you ever been diagnosed with any of the following?
(If you answer YES for any of the following, please explain problems, date of onset, whether medical advice was sought and results of treatment/evaluation)

YES	NO	
☐	☐	Diagnosed with heart or cardiovascular disease
☐	☐	Ankles swell regularly (edema)
☐	☐	Any respiratory problems (asthma, bronchitis, emphysema, difficulty breathing, reoccurring cough)
☐	☐	Any gastrointestinal problems that require ongoing treatment
☐	☐	Hypoglycemia
☐	☐	Back problems
☐	☐	Osteoporosis or Osteopenia
☐	☐	Any bone, muscle or joint condition, which might be aggravated by exercise If yes, what injury and when: _____ Describe the medical treatment received: _____ Do you have any restrictions due to this injury? _____ Other Explanations: _____ _____ _____
☐	☐	Are you currently pregnant? If YES, what month are you in? _____
☐	☐	Are you currently taking medication (including aspirin, cold medicines, herbal diet supplements)? If YES, please list:

Medication Name	Purpose	Dose	How Often
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE CHECK the appropriate box below for those, which apply to you (past or present)

☐ Aortic Aneurysm	☐ Arrhythmias	☐ Cancer	☐ Low Back Pain
☐ Bladder problems/Incontinence	☐ Excessive Fatigue	☐ Thyroid Problems	☐ Overweight
☐ Coronary Hear Disease	☐ Anemia	☐ Phlebitis	☐ Orthopedic Disorder
☐ Gastro/Intestinal Problems	☐ Skin Condition	☐ Epilepsy	☐ History of Surgery
☐ Musculoskeletal Disorder	☐ Arthritis	☐ Emotional Stress	☐ Ulcers
☐ Valvular Heart Disease	☐ Osteoporosis	☐ Kidney Disease	☐ Poor Exercise Tolerance

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Part 3: PHYSICAL ACTIVITY AND HEALTHY LIFESTYLE HISTORY

□ I rarely exercise I participate in exercise □ 2-3 days per week □ 5-7 days per week

Type of Activity (list all exercise, activities you regularly participate in)	**Part of Current Routine (Y or N)**	**PA in the past 4 months (Y or N)**	**Month/year stopped exercise. Reason why?**	**Minutes per exercise session**	**Number of days per week**	**Intensity Level (low, med, high)**
Aerobic (e.g. run, bike, swim, walk)						
Strength/Resistance Exercise						
Flexibility (e.g. Yoga)						

Fitness and Lifestyle Assessment with MWR Fitness Professional

YES NO

□ □ Are you interested in scheduling a fitness evaluation?

Why? □ to assess current health status

□ to begin or maintain a fitness program

□ to pass the PFA

□ to improve my activity/sport performance

□ to begin or maintain a weight control/maintenance program

□ to assess my current nutritional status

□ other:_____

□ □ Are you interested in a fitness consultation?

Why? _____

Any additional comments: _____

_____

_____

_____ _____

Signature Date

□ Pre-Activity FHHQ reviewed by _____ _____

MWR Fitness Professional Date